PRINTED: 02/02/2010 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUI COMPLET	
		297096	B. WIN	IG		12/1	1/2009
	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		JLD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	3	G	000			
	a result of the Medica conducted at your ag 12/11/09, in accordar Home Health Services The active census or was 161. Twenty-for reviewed, including for home visits were consulted to the Health Division prohibiting any criminactions or other claim available to any party state, or local laws.	the first day of the survey or clinical records were our closed records. Ten ducted. clusions of any investigation on shall not be construed as hal or civil investigations, has for relief that may be or under applicable federal,					
G 116	identified: 484.10(f) HOME HEA The patient has the ravailability of the toll- State. When the agency actreatment or care, the patient in writing of the hours of its operation hotline is to receive colocal HHAs. The patient	ight to be advised of the free HHA hotline in the cepts the patient for a HHA must advise the ne telephone number of the established by the State, the named that the purpose of the complaints or questions about the ent also has the right to use complaints concerning the end advanced	G	116			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	G		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	•	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 116	Continued From page	e 1	G	116			
	This STANDARD is r Surveyor: 25418	not met as evidenced by:					
	staff fully explained th	he agency failed to ensure ne availability of the 24 hour or 1 of 10 patients visited					
	Findings include:						
	Patient #1						
	including non-healing	ted on 8/1/09 with diagnoses surgical wound, abnormality ertension and chronic pain.					
G 121	Patient #1 indicated h	the availability of a toll free and when to use it. NCE W/ ACCEPTED	G	121			
	professional standard	f must comply with accepted Is and principles that apply shing services in an HHA.					
	Surveyor: 25418 Based on observatior failed to ensure the nu professionally accepted	not met as evidenced by: n and interview, the agency urse followed accepted ed standards and principles 4 patients (Patients #6, #8).					

DYNAMIC HOME HEALTH CARE, LLC B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
DYNAMIC HOME HEALTH CARE, LLC 2865 S JONES			297096	B. WIN	G		12/1	1/2009
			LLC		28	865 S JONES		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETION DATE
G 121 Continued From page 2 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. Patient #6 had three separate and distinct wounds on the lateral and posterior aspects of the left lower leg. On 12/11/09 during a home visit in the morning, the nurse performed wound care on the three wounds on Patient #5's left lower leg. While cleaning all three of Patient #6's wounds, the nurse wore the same pair of gloves. On 12/11/09 in the afternoon, the Nursing Supervisor (NS) indicated three separate and distinct wounds should be treated as such. The NS indicated she would expect the nurse to change gloves and perform hand hygiene after the care of the first wound and before the care of the second wound. The NS indicated she would expect to see the same glove change/hand hygiene procedure performed between provision of care to the second and third wounds. Patient #8 Patient #8 was admitted on 10/28/08 with diagnoses including insulin dependent diabetes mellitus, diabetic ulcer of the lower leg and chronic airway obstruction. On 12/4/09 in the morning during a home visit, the skilled nurse (SN) performed wound care to Patient #8's lower leg wound.	G 121	Patient #6 Patient #6 was admit diagnoses including vinsufficiency, maligna and morbid obesity. Patient #6 had three wounds on the lateral left lower leg. On 12/11/09 during at the nurse performed wounds on Patient #8 While cleaning all three hurse wore the same of the first wounds indicated she wo	ted on 9/30/08 with venous peripheral ant essential hypertension separate and distinct I and posterior aspects of the I home visit in the morning, wound care on the three 5's left lower leg. see of Patient #6's wounds, ame pair of gloves. Iternoon, the Nursing sated three separate and Id be treated as such. The suld expect the nurse to serform hand hygiene after ound and before the care of The NS indicated she would be glove change/hand erformed between provision and third wounds. Ited on 10/28/08 with insulin dependent diabetes or of the lower leg and action. Item on 10/28/08 with insulin dependent diabetes or of the lower leg and action.	G	121	DEFICIENCY)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WIN				
		297096				12/1	1/2009
	OVIDER OR SUPPLIER HOME HEALTH CARE, I	LLC		28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 121	Continued From page	e 3	G	121			
	SN removed both glo perform hand hygiene of gloves. On two oc only one glove withou prior to donning the n	Patient #8's wound care, the ves eight times and failed to e prior to donning a new pair casions, the SN changed ut performing hand hygiene new glove(s).					
G 143	Morbidity and Mortalit Recommendations &	ty Report MMWR Reports, published October ls, "J. Decontaminate gloves "	G	143			
	to ensure that their ef	ng services maintain liaison forts are coordinated rt the objectives outlined in					
	This STANDARD is r Surveyor: 25418	not met as evidenced by:					
	ensure employees ma coordinated in a way objectives outlined in	ew, the agency failed to aintained liaison and to effectively support the the plan of care for 9 of 24 #2, #7, #11, #12, #14, #15,					
	Findings include:						
	Patient #1						
	including non-healing	ted on 8/1/09 with diagnoses surgical wound, abnormality ertension and chronic pain.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	COMPLET	
		297096	B. WIN	IG_		12/1	1/2009
	OVIDER OR SUPPLIER	LLC		:	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	121	172003
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO TOTAL DEFICIENCE OF THE PROVIDER'S PLAN OF PROVIDE		LD BE	(X5) COMPLETION DATE
G 143	Continued From page	e 4	G	143	3		
	physical therapy (PT)						
	evidence the two disc each other regarding	ecord lacked documented siplines communicated with the patient's problems, e three certification periods					
	Patient #2						
	Patient #2 was admit diagnoses including p dependent diabetes, hypertension and det	oressure ulcer, non-insulin malignant essential					
	Patient #2 was seen physical therapy (PT)	by skilled nursing (SN) and					
	nurse visit note dated	ecord included a skilled I 11/15/09 with a notation the ing at her granddaughter's					
		ecord lacked documented ne PT was notified of the address.					
	Patient #3						
	Patient #3 was admit diagnoses including one neoplasm of the lung	decubitus ulcer, malignant					
	Patient #3 was seen physical therapy (PT)	by skilled nursing (SN) and					
	Patient #3's clinical re	ecord lacked documented					

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		297096	B. WIN	G		12/1	1/2009
	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	•	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 143	evidence SN and PT other regarding the p status. Patient #7 Patient #7 was admit diagnoses including of hypertension, non-insimellitus, bronchitis an obstruction. Patient #7 was seen physical therapy (PT) Patient #7's clinical revidence indicating S with each other regardineeds, progress, etc. Patient #11 Patient #11 was admidiagnoses including properties of the diabetes in hypertension and uring the certification of th	ted on 11/20/09 with debility, essential sulin dependent diabetes and chronic airway by skilled nursing (SN) and PT communicated and the patient's issues, by sential nursing the patient's issues, and physical therapy (PT). 25/09 from 11:00 AM to be SN sent Patient #11 to the ambulance. Sit form prepared by PT is not home didn't call to	G	143			

Facility ID: NVS534HHA

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLETI	
		297096	B. WIN	IG		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 143	two disciplines common regarding the patient." Patient #12 Patient #12 was admidiagnoses including eabnormality of gait and Patient #12 was seen physical therapy (PT) Patient #12's clinical evidence the two discipled each other regarding and progress. Patient #14 Patient #14 was origing with diagnoses included diabetes mellitus and extremities. Over the patient was readmitted three times: on 1/22/0 of wound(s) and subsection 4th and 5th left toes; wound; on 10/7/09 for bilateral below the kning to 10/13/09). Patient #14's most readmitted three times: on 1/2/09 for bilateral below the kning to 10/13/09. Patient #14's most readmitted threapy.	record lacked evidence the funicated with each other is status. itted on 11/15/09 with essential hypertension, and acute pain. In by skilled nursing (SN) and it. record lacked documented ciplines communicated with the patient's needs, issues mally admitted on 1/16/09 ling insulin dependent four wounds on the lower experience of 12 months, the end to the acute care setting to go for deterioration/infection sequent amputation of the on 8/26/09 for infection of or respiratory issues (and	G	143			
		sciplines communicated with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCT	TION	(X3) DATE SURVEY COMPLETED	
		297096	B. WING	·			
	OVIDER OR SUPPLIER	LLC		STREET ADDRESS, 2865 S JONES LAS VEGAS, N	CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EAC	ROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 143	diagnoses including in hypertension, and ast Patient #18 was seen physical therapy. The documented evidence communicated with e patient's needs, issue Patient #20 Patient #20 was admit diagnoses including in mellitus, pressure ulcineoplasm of the skin. Patient #20 was seen occupational therapy record lacked docume disciplines communic regarding the patient's progress/lack of	g the patient's issues, as. itted on 11/26/09 with muscle weakness, essential thma. by skilled nursing and eclinical record lacked the two disciplines ach other regarding the es and progress. itted on 7/10/09 with musulin dependent diabetes ers, debility and malignant by skilled nursing (SN) and (OT). The patient's clinical ented evidence the two ated with each other is needs, issues and ress. summary was signed by SN	G 1		DEFICIENCY)		
		minutes of case n that effective interchange, nation of patient care does					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		297096	B. WIN	G		12/1	1/2009
	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC		280	EET ADDRESS, CITY, STATE, ZIP CODE 65 S JONES AS VEGAS, NV 89146	,	2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCE		LD BE	(X5) COMPLETION DATE
G 144	Continued From pag	e 8	G	144			
	Surveyor: 25418 Based on record revireview, the agency faconferences occurred 24 patients (Patients) Findings include: Patient #11 Patient #11 was origing with diagnoses including assistant and A 10/14/09 skilled nutraing assistant and that date. Patient #11 was read diagnoses including a insulin dependent diagnoses includin	d on a regular basis for 3 of #11, #12, #14). Inally admitted on 9/17/09 ding pressure ulcers, non abetes mellitus, debility, on and urinary retention. In by skilled nursing, certified diphysical therapy. Irrsing visit note revealed to the emergency room on dimitted on 11/20/09 with debility, pressure ulcers, non abetes mellitus, debility and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		297096	B. WIN	IG_		12/1	1/2009
	NOVIDER OR SUPPLIER	LLC	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	,	2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTIVE		LD BE	(X5) COMPLETION DATE
	Continued From page abnormality of gait and Patient #12 was seen therapy and occupation Patient #12's clinical evidence the three disconference to discussissues, progress, etc. Patient #14 Patient #14 was original with diagnoses included in the discontent with the diagnoses included in the course of 12 readmitted to the accontent of 1/22/09 for deteric (and subsequent ampleft toes); on 8/26/09 10/7/09 for respirator the knee amputations. Patient #14's most reagency was on 11/6/seen by skilled nursing occupational therapy	and acute pain. In by skilled nursing, physical conal therapy. In particular therapy. In particular therapy. In particular therapy. In ally admitted on 1/16/09 and the patient's problems, In ally admitted on 1/16/09 and the patient therapy and therapy and the patient therapy and the pati		144	CROSS-REFERENCED TO THE APPRODEFICIENCY)	DPRIATE	DATE
	conference to discus issues, progress, etc On 12/11/09 in the at indicated "Case confimonth a list is prep	s the patient's problems,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	G		12/1 ⁻	1/2009
	OVIDER OR SUPPLIER	LLC	•	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 144 G 145	problem."	inless there is an ongoing		144 145			
		port for each patient is sent cian at least every 60 days.					
	This STANDARD is r Surveyor: 25418	not met as evidenced by:					
	ensure a complete 60	the physician for 3 of 24					
	Findings include:						
	Patient #1						
	certification period of two medications (Prindiscontinued. There	written for Patient #1's first 8/1/09 - 9/29/09 indicated ivil and Simvastatin) were was no explanation why the medications used to treat percholesteremia.					
	revealed the amount time. There was no in	losage was changed and the patient was taking at that indication what dosage the and what necessitated the					

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′			(X3) DATE SUR COMPLETE	
	297096	B. WIN	1G _		12/1	1/2009
OVIDER OR SUPPLIER	LLC	'	:	2865 S JONES		2000
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Continued From page	e 11	G	145	5		
included in the 60 day measurements of the of the 60 day period of current measurement the wound was debrig measurements before There was no docum and amount of drainal end) of certification properties of the first certification properties wound was treated who assisted closure). The indicating how the word and the reason for its the Patient #6 was admitted diagnoses including who insufficiency, malignation and morbid obesity. As of 12/11/09, Patient distinct wounds on the aspects of the left low indicated "as soon as appears." The 60 day summary 9/25/09 - 11/23/09 recopen areas on the low of both wounds did not one. There were not of the certification periods.	y summary. There were no wound from the beginning with which to compare the se. There was no indication ded (and when) and the e and after the procedure. The entation regarding the type ge at the beginning (and eriod. The example of the beginning (and eriod) eriod (vacuum ere was no documentation eriod eriod) eriod the example of the beginning eriod eri					
	OVIDER OR SUPPLIER HOME HEALTH CARE, I SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I Continued From page Patient #1's current wincluded in the 60 day measurements of the of the 60 day period wincurrent measurement the wound was debrid measurements before There was no docume and amount of drainal end) of certification period wound was treated with assisted closure). The indicating how the wound was treated with assisted closure in the wound was treated with assisted closure. The indicating how the wound was including with indicating how the wound the reason for its. Patient #6 Patient #6 was admitted diagnoses including with insufficiency, malignated and morbid obesity. As of 12/11/09, Patient distinct wounds on the aspects of the left low indicated "as soon as appears." The 60 day summary 9/25/09 - 11/23/09 recomposed areas on the low of both wounds did not one. There were no reference in the current measurement measureme	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Patient #1's current wound measurements were included in the 60 day summary. There were no measurements of the wound from the beginning of the 60 day period with which to compare the current measurements. There was no indication the wound was debrided (and when) and the measurements before and after the procedure. There was no documentation regarding the type and amount of drainage at the beginning (and end) of certification period. During the first certification period, Patient #1's wound was treated with a wound VAC (vacuum assisted closure). There was no documentation indicating how the wound responded to the VAC and the reason for its discontinuation. Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. As of 12/11/09, Patient #6 had three separate and distinct wounds on the medial and posterior aspects of the left lower leg. The skilled nurse indicated "as soon as one heals, another one	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 G Patient #1's current wound measurements were included in the 60 day summary. There were no measurements of the wound from the beginning of the 60 day period with which to compare the current measurements. There was no indication the wound was debrided (and when) and the measurements before and after the procedure. There was no documentation regarding the type and amount of drainage at the beginning (and end) of certification period, Patient #1's wound was treated with a wound VAC (vacuum assisted closure). There was no documentation indicating how the wound responded to the VAC and the reason for its discontinuation. Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. As of 12/11/09, Patient #6 had three separate and distinct wounds on the medial and posterior aspects of the left lower leg. The skilled nurse indicated "as soon as one heals, another one appears." The 60 day summary for the certification period of 9/25/09 - 11/23/09 revealed Patient #6 had two open areas on the lower left leg. The description of both wounds did not include the depth of either one. There were no measurements from the start of the certification period with which to compare the current measurements. There was no	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Patient #1's current wound measurements were included in the 60 day summary. There were no measurements of the wound from the beginning of the 60 day period with which to compare the current measurements. There was no indication the wound was debrided (and when) and the measurements before and after the procedure. There was no documentation regarding the type and amount of drainage at the beginning (and end) of certification period. During the first certification period, Patient #1's wound was treated with a wound VAC (vacuum assisted closure). There was no documentation indicating how the wound responded to the VAC and the reason for its discontinuation. Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. As of 12/11/09, Patient #6 had three separate and distinct wounds on the media. The process of the left lower leg. The skilled nurse indicated "as soon as one heals, another one appears." The 60 day summary for the certification period of 9/25/09 - 11/23/09 revealed Patient #6 had two open areas on the lower left leg. The description of both wounds did not include the depth of either one. There were no measurements from the start of the certification period with which to compare the current measurements. There was no	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Patient #1's current wound measurements were included in the 60 day summary. There were no measurements of the wound from the beginning of the 60 day period with which to compare the current measurements. There was no indication the wound was debrided (and when) and the measurements before and after the procedure. There was no documentation indicating how the wound vas treated with a wound VAC (vacuum assisted closure). There was no documentation indicating how the wound responded to the VAC and the reason for its discontinuation. Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. As of 12/11/09, Patient #6 had three separate and distinct wounds on the medial and posterior aspects of the left lower leg. The skilled nurse indicated "as soon as one heals, another one appears." The 60 day summary for the certification period of 9/25/09 - 11/23/09 revealed Patient #6 had two open areas on the lower left leg. The description of both wounds did not include the depth of either one. There were no measurements from the start of the certification period with which to compare the current measurements. There was no	OVIDER OR SUPPLIER 297096 STREET ADDRESS, CITY, STATE, ZIP CODE 2869 S JONES SUMMARY STATEMENT OF DEFICIENCES BLAS VEGAS, NV 89146 CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY DEFICIENCY CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY DEFICIENCY TAG CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY FROM DEF

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL				
		297096	B. WIIN			12/1	1/2009
	OVIDER OR SUPPLIER HOME HEALTH CARE,	LLC		28	EET ADDRESS, CITY, STATE, ZIP CODE 65 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 145	period of 9/25/09 - 11 progress toward goal certification period's F Patient #9 Patient #9 Patient #9 was admitt diagnoses including pessential hypertensio pain. Patient #9's 60 day siperiod 8/24/09 - 10/22 a) mention of a trip to medications for a urin b) wound measurement the certification period current measurement	ummary for the certification 1/23/09 did not include s indicated in the previous Plan of Care goals section. Ited on 2/25/09 with pressure ulcer of the buttock, an, obesity and low back ummary for the certification 2/09 did not include: Urgent Care and new pary tract infection; ents from the beginning of d with which to compare the tas; a cream to the wound as ardry Ag (silver) skin	G	145	DEFICIENCY)		
G 158	484.18 ACCEPTANC MED SUPER Care follows a writter	E OF PATIENTS, POC, n plan of care established wed by a doctor of medicine,	G	158			
	This STANDARD is a Surveyor: 25418	not met as evidenced by:					
	Based on record revie	ew and document review,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUF	
	297096	B. WIN	G		12/1	1/2009
NAME OF PROVIDER OR SUPPLIER DYNAMIC HOME HEALTH CARE, L	rc	•	28	EET ADDRESS, CITY, STATE, ZIP CODE 65 S JONES AS VEGAS, NV 89146	,	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
established written pla physician for 12 of 24 #3, #10, #11, #14, #17 Findings include: Patient #1 Patient #1 was admitt including non-healing of gait, essential hype Patient #1's Plan of C certification period of skilled nursing (SN) to week for one week an seven weeks. As revealed by the mi 8/19 and 8/21/09, SN during the fourth weel Missed visit forms dat and 9/28/09 revealed for the ordered numbe and 7 of the certification Patient #1's clinical re orders decreasing the during the affected we Patient #1's POC inclu vac (vacuum assisted The order did not spe- continuous or intermit SN notes dated 8/3, 8	nsure care followed an an periodically reviewed by a patients (Patients #1, #2, 7, #19, #20, #22, #23, #24). ed on 8/1/09 with diagnoses surgical wound, abnormality entension and chronic pain. are (POC) for the 8/1/09 - 9/29/09 called for 2 see the patient one time a 3 and three times a week for a seed visit forms dated 8/17, did not see Patient #1 k. seed 8/28, 9/3, 9/8, 9/9, 9/10 SN did not see Patient #1 er of visits during weeks 5, 6 on period 8/1/09 - 9/29/09. second lacked physician's a frequency of SN visits eeks. sudded orders for "wound a closure) at 175 (mm/hg)." cify if the setting was to be	G	158			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILE			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	IG _		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	'	:	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF COMPRETIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY		TION SHOULD BE THE APPROPRIATE	
G 158	was continuous or interest Patient #2 Patient #2 was admitted diagnoses including proceeding to dependent diabetes, hypertension and determined proceeding to determine the transfer of the t	d not reveal if the setting ermittent. ted on 11/14/09 with pressure ulcer, non-insuling malignant essential polity. Care (POC) for the 11/14/09 - 1/12/10 called for the 20 see the patient two times and even times a week for one mes a week. Intation in Patient #2's with the patient two times the mes the second week. The many properties of the second week week. Ited on 8/24/09 with decubitus ulcer malignant and low back pain. Care (POC) for the 8/24/09 - 10/22/09 called for the see the patient three times	G	158			
	problems. As of 9/6/0 in Patient #3's certific	09, only six weeks remained ation period.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	COMPLETED	
		297096	B. WIN	IG_	 	12/1	1/2009	
	NOVIDER OR SUPPLIER	LLC	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 1865 S JONES LAS VEGAS, NV 89146	,	2000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
G 158	Patient #3's clinical retherapy (PT) evaluation was no order for PT or clinical record. PT wrote for a frequency one week and two times and two times are revidence of 12/3/09, the order physician. Patient #3's clinical revidence of 14 SN vince 10/22/09. The clinical missed visit forms. To visits were unaccountered with two times and patient #3's POC for 10/23/09 - 12/21/09 in the patient two times and print wound complicate the patient two times and print wound complicate the patient wound complicated the pa	ecord included a physical ion dated 9/26/09. There evaluation in the patient's ency of one time a week for mes a week for four weeks. Ider was not signed by the ecord lacked documented sits from 8/31/09 through all record included three. The rest of the 11 ordered ited for. Ithe certification period of included orders for SN to see a week for nine weeks with ations. In a week for nine weeks with ations.	G	158				
	The resumption of ca #3 indicated the patie day for five days in a lacked documented e 11/21/09. There was 11/21/09. There was	are (ROC) order for Patient ent was to be seen once a row. The clinical record evidence of a SNVN for s no missed visit form dated a no physician's order per of SN visits for that week.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	IG_		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	1	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 158	Continued From page	e 16	G	158	3		
	diagnoses including of hypertension and def						
	physical therapy (PT)	- · · · · · · · · · · · · · · · · · · ·					
	skilled nursing (SN) o	• •					
	record, SN saw the p	s in Patient #10's clinical atient once a week for five ne missed visit form (dated al record.					
	Patient #10 on Friday order for the patient to	nded on Sunday. OT saw r, 11/20/09 and wrote an o be seen three times a The order did not specify, of 11/23/09"					
	Patient #11						
		pressure ulcer, non insulin nellitus, debility, essential					
		record contained a cian's Order dated by the ealing new wound card					
	As of 12/11/09, Patie	nt #11's clinical record					

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		297096	B. WIN	IG		12/1	1/2009
	NOVIDER OR SUPPLIER	LLC	'	28	EET ADDRESS, CITY, STATE, ZIP CODE 65 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 158	Patient #14 Patient #14 was origi with diagnoses includidabetes mellitus and extremities. Over the course of 12 readmitted to the acu on 1/22/09 for detericand subsequent amptoes; on 8/26/09 for in 10/7/09 for respirator the knee amputations Patient #14's most re on 11/6/09 (during the 11/11/09). The patiskilled nursing, physicalled nursing, physicalled nursing, order to reservices at a frequent two weeks. There was left in the certification. Patient #14's clinical physician's order to reservices at a frequent week and two times a clinical record lacked two PT visits during the Patient #14's clinical	plementary Physician's Ordering the wound care protocol. Inally admitted on 1/16/09 Iling insulin dependent four wounds on the lower It months, Patient #14 was the care setting three times: Pration/infection of wound(s) Putation of the 4th and 5th left Infection of wound; on The sisues (and bilateral below The son 10/13/09). In the sisues (and bilateral below The son 10/13/09). The sisues (and bilateral below The son 10/13/09 are was The certification period 9/13/09 The sisues skilled nursing (SN) The sisues than one full week The documented evidence of The week of 11/9/09. The sisues of three weeks. The The documented evidence of The week of 11/9/09. The sisues of three weeks and the sisues of the week of 11/9/09. The sisues of three weeks and the sisues of the week of 11/9/09. The sisues of three weeks and the sisues of the week of 11/9/09. The sisues of three weeks and the sisues of the week of 11/9/09.	G	158			
	physician's order to re	esume occupational therapy					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	G		12/1	1/2009
	ROVIDER OR SUPPLIER	LLC	'	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 158	(OT) services at a free one week, two times once a week for one week for week for week for week for week for week for 12/16/109. Patient #17's Plan of skilled nursing to see days. The clinical rector of 12/2/09. Patient #17's clinical rector of 12/2/09. Patient #17's clinical rector of 12/2/09. Patient #17's clinical rector of 12/2/09. Patient #19's clinical rector of 12/2/09. Patient #19 was adm diagnoses including a the abdominal wall, or right buttock and non mellitus. Patient #19's Plan of skilled nursing (SN) to disease process, con complications and howounds NIDDM (no week for one week for on	quency of once a week for a week for three weeks and week. record lacked documented during the weeks of 11/6/09 itted on 12/1/09 with coronary artery disease and ers. Care included orders for the patient every day for 14 cord lacked a nursing note record did not include a cating 1) why the patient the physician was notified of a no physician's order sits. itted on 11/13/09 with an open surgical wound of pen surgical wound of the insulin dependent diabetes Care included orders for or " instruct regarding trol of risk factors, possible me management of open	G	158			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	IG		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	•	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 158	side effects, interaction medications nutrition glucometer, diabetic in s/sx infection, infection s/sx infection s/sx infection, infection s/sx infec	ons, uses, frequency, dose, ons of all new/changed nal/hydration needs, use of management, skin/foot care, ction control" Id nursing visit notes (SNVN) instructed Patient #19 recautions eight times, is, general hygiene three of times (one included lis)), general wound care two is one time, open wound in nine times, medications I precautions two times, is and skin care of the in Patient #19's SNVNs was was no documentation at the patient was taught edications (dose, frequency effects), specific foods and is die and wound healing. In procumented evidence Patient ver verbalized ling the information the cocumented evidence Patient ver gave a return wound care.	G	158			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
	297096	B. WIN	G		12/1	12/11/2009	
OVIDER OR SUPPLIER	LLC	•	28	865 S JONES	1271		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	.D BE	(X5) COMPLETION DATE	
fall. A SNVN dated 11/23/ "deep tunneling" of Paragraphic Paragraphic Patchanges in the wound changes in the wound procumentation on senursing notes revealed non-compliant with must be revealed non-compliant w	209 revealed there was atient #19's buttock wound. Exceed documented evidence itent #19's physician of discondition. Exercise of Patient #19's discondition. Exercise the patient was edications. Exercise the physician was notified compliance with Extended on 7/10/09 with insulin dependent diabetes ers, malignant neoplasm of Exercise (POC) included orders increased (SN) every day for Exercise the physician was notified orders increased documented patient on 7/20/09 and ino missed visit forms and was notified of the missed cord lacked a physician's visits. Excluded orders for (OT) to evaluate the patient.	G	158	DETICIENT)			
	CORRECTION COVIDER OR SUPPLIER HOME HEALTH CARE, I SUMMARY STA (EACH DEFICIENCY REGULATORY OR I. Continued From page fall. A SNVN dated 11/23/ "deep tunneling" of Pathen the nurse notified Pathen changes in the wound Documentation on seen ursing notes revealed non-compliant with more of Patient #19's non-compliant with more was no evidence of Patient #20 Patient #20 Patient #20 Patient #20 was admit diagnoses including in mellitus, pressure ulcountered the skin and debility. Patient #20's Plan of to be seen by skilled in the skin and debility. Patient #20's clinical in evidence SN saw the 7/24/09. There were indicating the physicial visits. The clinical recorder decreasing SN Patient #20's POC inconcupational therapy	CORRECTION DENTIFICATION NUMBER: 297096 OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 fall. A SNVN dated 11/23/09 revealed there was "deep tunneling" of Patient #19's buttock wound. The clinical record lacked documented evidence the nurse notified Patient #19's physician of changes in the wound condition. Documentation on several of Patient #19's nursing notes revealed the patient was non-compliant with medications. There was no evidence the physician was notified of Patient #19's non-compliance with medications. Patient #20 Patient #20 Patient #20 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, malignant neoplasm of the skin and debility. Patient #20's Plan of Care (POC) included orders to be seen by skilled nursing (SN) every day for	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 fall. A SNVN dated 11/23/09 revealed there was "deep tunneling" of Patient #19's buttock wound. The clinical record lacked documented evidence the nurse notified Patient #19's physician of changes in the wound condition. Documentation on several of Patient #19's nursing notes revealed the patient was non-compliant with medications. There was no evidence the physician was notified of Patient #19's non-compliance with medications. Patient #20 Patient #20 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, malignant neoplasm of the skin and debility. Patient #20's Plan of Care (POC) included orders to be seen by skilled nursing (SN) every day for 21 days. Patient #20's clinical record lacked documented evidence SN saw the patient on 7/20/09 and 7/24/09. There were no missed visit forms indicating the physician was notified of the missed visits. The clinical record lacked a physician's order decreasing SN visits. Patient #20's POC included orders for occupational therapy (OT) to evaluate the patient.	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 fall. A SNVN dated 11/23/09 revealed there was "deep tunneling" of Patient #19's buttock wound. The clinical record lacked documented evidence the nurse notified Patient #19's physician of changes in the wound condition. Documentation on several of Patient was non-compliant with medications. There was no evidence the physician was notified of Patient #19's non-compliance with medications. Patient #20 Patient #20 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, malignant neoplasm of the skin and debility. Patient #20's Plan of Care (POC) included orders to be seen by skilled nursing (SN) every day for 21 days. Patient #20's clinical record lacked documented evidence SN saw the patient on 7/20/09 and 7/24/09. There were no missed visit forms indicating the physician was notified of the missed visits. The clinical record lacked a physician's order decreasing SN visits. Patient #20's POC included orders for occupational therapy (OT) to evaluate the patient.	CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WINO	COMPLET 297096 297096 297096 297096 297096 2010ER OR SUPPLIER COMPLET 2868 S JONES SUMMARY STATE. ZIP CODE 2868 S JONES SUMMARY STATE. ZIP CODE 2868 S JONES LAS VEGAS, NV 89146 SUMMARY STATE STATE OF DEPICIENCES LAS VEGAS, NV 89146 SUMMARY STATE STATE STATE OF DEPICIENCES LAS VEGAS, NV 89146 SUMMARY STATE STATE STATE OF DEPICIENCES LAS VEGAS, NV 89146 PROVIDERS PLAN OF CORRECTION (FRACHOGRAFOUTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COntinued From page 20 fall. A SNVN dated 11/23/09 revealed there was "deep tunneling" of Patient #19's buttock wound. The clinical record lacked documented evidence the nurse notified Patient #19's physician of changes in the wound condition. Documentation on several of Patient #19's nursing notes revealed the patient was non-compliant with medications. There was no evidence the physician was notified of Patient #120 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, malignant neoplasm of the skin and debility. Patient #20 s Plan of Care (POC) included orders to be seen by skilled nursing (SN) every day for 21 days. Patient #20's Plan of Care (POC) included orders to be seen by skilled nursing (SN) every day for 21 days. Patient #20's Plan of Lacked a physician's order decreasing SN visits. Patient #20's POC included orders for occupational therapy (OT) to evaluate the patient.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	G		12/1	1/2009
	ROVIDER OR SUPPLIER HOME HEALTH CARE, I	TC	,	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 158	was evaluated six day Patient #20's OT order one time a week for si Patient #20's clinical evidence of an OT vis 7/20/09. There was rephysician was notified clinical record lacked decreasing the frequence of the following record lacked decreasing the frequence of the following record lacked decreasing the frequence of the following record for t	ers were for a frequency of ix weeks. record lacked documented sit during the week of no documented evidence the dof the missed visit. The a physician's order ency of OT visits. Itted on 5/21/09 with non insulin dependent evarthrosis, chronic pain Care included orders for (a) to see the patient three weeks and then, two times a constant of Patient #22's there was no documentation aluated the patient six days I therapy (PT) Resumption 199 included orders for PT	G	158			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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OVIDER OR SUPPLIER	LLC	,	2	865 S JONES		
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Patient #22's clinical forms indicating why evidence the physicia visits, and an order dept visits. Patient #23 Patient #23 Patient #23 was adm diagnoses including a gait, long term use of the evaluation revea PT for the first time of documented evidence see the patient within the patient #23's Plan of for physical therapy (times a week for three indication the visits with the patient #23's clinical patient three times a then, one time a week Patient #24 Patient #24 Patient #24 was adm diagnoses including of pneumonia and convertified nursing assistance week and then, the weeks. According to docume	record lacked missed visit the patient was not seen, an was notified of the missed ecreasing the frequence of sitted on 5/22/09 with acute pain, abnormality of anticoagulants and debility. Iled Patient #23 was seen by no 5/27/09. There was no se indicating why PT did not 48 hours of the referral. Care (POC) included orders PT) to see the patient three se weeks. There was no ere to start on 5/27/09. In record revealed PT saw the week for the first week and k for two weeks. Itted on 5/15/09 with cerebral palsy, dysphagia, ulsions. Care included orders for stant (CNA) once a week for wo times a week for eight intation in the clinical record,	G	158			
the CNA did not see	Patient #24 the first week					
	CORRECTION COVIDER OR SUPPLIER HOME HEALTH CARE, SUMMARY ST. (EACH DEFICIENC REGULATORY OR IN ITEM PROPERTIES IN ITEM PROPER	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Patient #22's clinical record lacked missed visit forms indicating why the patient was not seen, evidence the physician was notified of the missed visits, and an order decreasing the frequence of PT visits. Patient #23 Patient #23 Patient #23 was admitted on 5/22/09 with diagnoses including acute pain, abnormality of gait, long term use of anticoagulants and debility. The evaluation revealed Patient #23 was seen by PT for the first time on 5/27/09. There was no documented evidence indicating why PT did not see the patient within 48 hours of the referral. Patient #23's Plan of Care (POC) included orders for physical therapy (PT) to see the patient three times a week for three weeks. There was no indication the visits were to start on 5/27/09. Patient #23's clinical record revealed PT saw the patient three times a week for two weeks. Patient #24 Patient #24 was admitted on 5/15/09 with diagnoses including cerebral palsy, dysphagia, pneumonia and convulsions. Patient #24's Plan of Care included orders for certified nursing assistant (CNA) once a week for one week and then, two times a week for eight	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Patient #22's clinical record lacked missed visit forms indicating why the patient was not seen, evidence the physician was notified of the missed visits, and an order decreasing the frequence of PT visits. Patient #23 Patient #23 was admitted on 5/22/09 with diagnoses including acute pain, abnormality of gait, long term use of anticoagulants and debility. The evaluation revealed Patient #23 was seen by PT for the first time on 5/27/09. There was no odcumented evidence indicating why PT did not see the patient within 48 hours of the referral. Patient #23's Plan of Care (POC) included orders for physical therapy (PT) to see the patient three times a week for three weeks. There was no indication the visits were to start on 5/27/09. Patient #23's clinical record revealed PT saw the patient three times a week for two weeks. Patient #24 was admitted on 5/15/09 with diagnoses including cerebral palsy, dysphagia, pneumonia and convulsions. Patient #24's Plan of Care included orders for certified nursing assistant (CNA) once a week for one week and then, two times a week for eight weeks. According to documentation in the clinical record,	OVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Patient #22's clinical record lacked missed visit forms indicating why the patient was not seen, evidence the physician was notified of the missed visits, and an order decreasing the frequence of PT visits. Patient #23 Patient #23 Patient #23 was admitted on 5/22/09 with diagnoses including acute pain, abnormality of gait, long term use of anticoagulants and debility. The evaluation revealed Patient #23 was seen by PT for the first time on 5/27/09. There was no documented evidence indicating why PT did not see the patient within 48 hours of the referral. Patient #23's Plan of Care (POC) included orders for physical therapy (PT) to see the patient three times a week for three weeks. There was no indication the visits were to start on 5/27/09. Patient #23's clinical record revealed PT saw the patient three times a week for three weeks. There was no indication the visits were to start on 5/27/09. Patient #23's clinical record revealed PT saw the patient three times a week for two weeks. Patient #24 Patient #24 Patient #24 was admitted on 5/15/09 with diagnoses including cerebral palsy, dysphagia, pneumonia and convulsions. Patient #24's Plan of Care included orders for certified nursing assistant (CNA) once a week for eight weeks. According to documentation in the clinical record,	CONTRECTION DENTIFICATION NUMBER 297096 B. WING	CONTINUENCE TO SUPPLIER 297096 297096 297096 25TREET ADDRESS, CITY, STATE, ZIP CODE 2866 S JONES SUMMARY STATEMENT OF DEPOSITIONS (EACH DEPOSITION OF DEPOSITIONS) (EACH DEPOSITION OF DEPOSITIONS) (EACH DEPOSITION OF DEPOSITIONS) (EACH DEPOSITION OF LISC IDENTIFYING INFORMATION) COntinued From page 22 Patient #22's clinical record lacked missed visit forms indicating why the patient was not seen, evidence the physician was notified of the missed visits, and an order decreasing the frequence of PT visits. Patient #23 Patient #23 Patient #23 Patient #23 Patient #23 Patient #23 was admitted on 5/22/09 with diagnoses including acute pain, abnormality of gait, long term use of anticoagulants and debility. The evaluation revealed Patient #23 was seen by PT for the first time on 5/27/09. There was no not documented evidence indicating why PT did not see the patient within 46 hours of the referral. Patient #23's Plan of Care (POC) included orders for physical therapy (PT) to see the patient three times a week for three was no indication the visits were to start on 5/27/09. Patient #24 Patient #24 was admitted on 5/15/09 with diagnoses including cerebral palsy, dysphagia, pneumonia and convulsions. Patient #24's Plan of Care included orders for certified nursing assistant (CNA) once a week for one week and then, two times a week for eight weeks. According to documentation in the clinical record,

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		297096	B. WIN		·	12/1	1/2009
	OVIDER OR SUPPLIER			28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146	12/1	1/2009
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 158	On 12/11/09 in the af Supervisor indicated disciplines to evaluate time the referral was According to the ager effective 05/08, " Privisit does not change communication note in the circumstances of physician must be no changes the frequency notified and an order the frequency" 484.18(a) PLAN OF 0	ternoon, the Nursing the policy for additional e was 48 hours from the received. hey's Plan of Care Policy, rocedure7. f. If a missed the frequency, a must be written explaining the missed visit and the tified. If a missed visit by, the physician must be must be obtained to change		158			
	equipment required, for prognosis, rehabilitati limitations, activities prequirements, medical safety measures to prinstructions for timely any other appropriate. This STANDARD is a Surveyor: 25418 Based on record reviewagency failed to ensure supplies were included.	requency of visits, on potential, functional permitted, nutritional ations and treatments, any rotect against injury, discharge or referral, and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297096	B. WIN	IG		12/1	1/2009
	ROVIDER OR SUPPLIER	LLC	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLET			
G 159	neoplasm of the lung Patient #3's Plan of C gloves, 4x4's (gauze) Tegaderm and walke On 12/3/09 in the after Patient #2 had a bedichair, a manual wheele concentrator, oxygen tanks. Patient #5 Patient #5 Patient #5 was admitt diagnoses including prabnormality of gait, a musculoskeletal syster disease. Patient #5's Plan of C gloves." On 12/3/09 in the mo Patient #5 had a bedical syster a small volume nebuling pratient #6 Patient #6 Patient #6 was admitt diagnoses including to	ted on 8/24/09 with decubitus ulcer malignant and low back pain. Care (POC) listed "non-sterile of the saline, Duoderm, of the saline, an oxygen of the saline, an oxygen of the saline, and portable oxygen of the saline, and the saline, and the saline, and the saline, and the saline, of the saline, and the saline, an	G	159			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		297096	B. WIN	IG		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	, <u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 159	Continued From page	e 25	G	159			
	,	OC) for the certification /22/10 listed "non-sterile					
	Patient #6 indicated s walk-in shower (this walk-in	nd held shower unit, a walker here were multiple wound					
	Patient #7						
	Patient #7 was admit diagnoses including of hypertension, non-insimellitus, bronchitis ar obstruction.	debility, essential sulin dependent diabetes					
	Patient #7's Plan of C gloves."	Care listed "non-sterile					
		rning during a home visit, ker and a small volume					
	Patient #8						
	Patient #8 was admit diagnoses including i mellitus, diabetic ulce chronic airway obstru	nsulin dependent diabetes er of the lower leg and					
	Patient #8's Plan of C gloves."	Care listed "non-sterile					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297096	B. WING			12/11/2009	
	OVIDER OR SUPPLIER	LLC		28	EET ADDRESS, CITY, STATE, ZIP CODE 65 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 159	Continued From page	e 26	G 1	59			
		e morning during a home a manual wheelchair and a					
	Patient #9						
		ted on 2/25/09 with pressure ulcer of the buttock, n, obesity and low back					
	Patient #9's Plan of C gloves."	Care listed "non-sterile					
	Patient #9 had a hosp	, a transfer board and					
	Patient #12						
	Patient #12 was admi diagnoses including e abnormality of gait an	essential hypertension,					
	Patient #12's Plan of gloves."	Care listed "non-sterile					
		rning during a home visit, lker, manual wheelchair, and held shower and					
	Patient #13						
	Patient #13 was admi diagnoses including of dependent diabetes n	osteomyelitis, insulin					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		297096	B. WING _		12	/11/2009
	NOVIDER OR SUPPLIER	LLC		REET ADDRESS, CITY, STATE, ZIP CO 2865 S JONES LAS VEGAS, NV 89146	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 159	atherosclerosis. Patient #13's Plan of gloves and wound cate of the patient #13 had a material and five small portable 484.18(a) PLAN OF Orders for therapy set procedures and mode amount, frequency, at this STANDARD is Surveyor: 25418 Based on record reviensure orders included.	brillation and coronary Care listed non-sterile are supplies. ernoon during a home visit, anual wheelchair, a reacher ale oxygen tanks. CARE ervices include the specific alities to be used and the and duration. not met as evidenced by: ew, the agency failed to eed all necessary a plan of care for 1 of 24	G 15			
G 165	mellitus, pressure uld neoplasm of the skin The OT evaluated Pa OT orders lacked do frequency was effect 484.18(c) CONFORM ORDERS	insulin dependent diabetes cers, debility and malignant . atient #20 on 7/17/09. The cumentation indicating the	G 16	5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		297096	B. WING			12/11/2009	
	OVIDER OR SUPPLIER	LLC	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 165	Continued From page agency staff only as o	e 28 ordered by the physician.	G	165	5		
	This STANDARD is a Surveyor: 25418	not met as evidenced by:					
	ensure drugs and trea	ew, the agency failed to atments were administered e physician for 8 of 24 #2, #3, #9, #10, #18, #22,					
	Findings include:						
	Patient #1						
	including non-healing	ted on 8/1/09 with diagnoses surgical wound, abnormality ertension and chronic pain.					
	nurse placed Xerofor	ring (SN) note revealed the m gauze on Patient #1's ere were no orders in the oform gauze.					
	the nurse placed Ada	8/13 and 8/15/09 revealed ptic dressing to Patient #1's ere were no orders in the aptic dressing.					
	nurse placed Mepitel	and 8/26/09 revealed the to Patient #1's exposed no orders in the clinical					
	Patient #2						
	Patient #2 was admitted	ted on 11/14/09 with pressure ulcer, non-insulin					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	B. WING		12/11/2009	
	OVIDER OR SUPPLIER	LLC	·	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 165	for wound care readir (normal saline), apply sterile dressing)." According to a skilled dated 11/19/09, the n and received an orde wound care to "Duode times a week)." Documentation on the the nurse used "Skin prior to applying the E #2's wound. Patient #2's clinical reevidence of a physicial Patient #3 Patient #3 was admitt diagnoses including one plasm of the lung. Patient #3's clinical renursing visit note (SN According to the notal was unscheduled and had an increase in collinical resulting the patient #3's clinical renursing visit note (SN According to the notal was unscheduled and had an increase in collinical resulting the patient #3's clinical resulting the	malignant essential bility. Fare (POC) included orders ag, "cleanse with NS in hydrogel and DSD (dry nurse visit note (SNVN) urse called the physician in to change Patient #2's earn patch 2xweek (two example 11/19/09 SNVN revealed prep to peri-wound area. Duoderm patch to Patient ecord lacked documented earls order for skin prep. The document of the document	G	165			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF	
		297096	B. WIN	IG		12/1	1/2009
	OVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 165	Continued From page	e 30	G	165			
		ted on 2/25/09 with pressure ulcer of the buttock, on, obesity and low back					
	physician's order for (by mouth) every day	e 11/16/09 SNVN indicated a Docusate 200 milligrams po was obtained. Patient #9's a physician's order for					
	Patient #10						
	Patient #10 was adm diagnoses including of hypertension and del						
	period included order to see the patient one	Care for the certification rs for the skilled nurse (SN) e time a week for one week, or one week and one time a					
	11/16/09. The clinical	one time during the week of al record lacked documented an's order for a SN visit the					
	Patient #18						
		itted on 11/26/09 with muscle weakness, essential thma.					
	to see the patient one	Care included orders for PT e time a week for one week, one week and then, three e weeks.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	1G _		12/1 [.]	1/2009
	OVIDER OR SUPPLIER	LLC	1		REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 165	Continued From page	e 31	G	165	5		
	indicating PT saw the	record included visit notes patient one time a week for aree times a week for one					
	Patient #22						
		itted on 5/21/09 with non insulin dependent eoarthrosis, chronic pain					
		I therapy (PT) Resumption /09 included orders for PT four weeks.					
	indicated PT saw the three weeks, did not	tient #22's clinical record patient two times a week for see the patient for one week; two times a week for one					
	order dated 7/8/09 for once a week for six w	record included a physician's r skilled nursing (SN) visits veeks. The patient was seen ng the week of 7/13/09.					
	Patient #23						
		itted on 5/22/09 with acute pain, abnormality of anticoagulants and debility.					
	Patient #23 was seer	n by physical therapy (PT).					
	order from the physic	red nurse took a verbal ian's office for Patient #23. (discontinue) SN (skilled					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		E CONSTRUCTION	(X3) DATE SI COMPLE	
		297096	B. WIN	IG		12/	11/2009
	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	1	286	ET ADDRESS, CITY, STATE, ZIP CODE 55 S JONES S VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 166	nursing) servicesP The order did not incland duration of visits According to docume clinical record, PT saweek for one week, oweeks, did not see that then, two times a week the week of 6/15/09. 484.18(c) CONFORMORDERS Verbal orders are put dated with the date onurse or qualified the	It services to continue." Itude the amount, frequency PT was to provide. Intation in Patient #23's we the patient two times a cone time a week for two he patient for one week and ek for one week, beginning MANCE WITH PHYSICIAN It in writing and signed and of receipt by the registered erapist (as defined in section presponsible for furnishing or		166			
	Surveyor: 25418 Based on record reviensure physicians' or in a timely manner fo #9). Findings include: Patient #3 Patient #3 was admit	decubitus ulcer, malignant and low back pain.					

Facility ID: NVS534HHA

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297096	B. WING		12/11/2009	
	ROVIDER OR SUPPLIER HOME HEALTH CARE, I		2	REET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES .AS VEGAS, NV 89146	12/1	172003
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 166	physician's orders, da 10/9/09. As of 12/3/0 physician's signature On 9/26/09, PT wrote have treatments one and two times a week 12/3/09, the order was physician. Patient #9 Patient #9 was admitt diagnoses including pessential hypertensio pain. As of 12/8/09, Patient certification period 10 physician's signature 484.30(a) DUTIES Of NURSE The registered nurse progress notes, coord physician and other period to the patient's condition and the surveyor: 25418 Based on record revise ensure the nurse pregaccurate physician's of the signature of the surveyor of the su	ated 9/6/09, 10/6/09 and 9, all three orders lacked a and date. If an order for Patient #3 to time a week for one week a for four weeks. As of its not signed or dated by the steed on 2/25/09 with oressure ulcer of the buttock, in, obesity and low back If #9's Plan of Care for the 1/23/09 - 12/21/09 lacked a and date. If THE REGISTERED If the REGISTERED If the resonnel of changes in the deneeds. If the agency failed to bared complete and orders, clinical notes and of 24 patients (Patients #1,	G 166			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297096	B. WIN	B. WING		12/11/2009	
	OVIDER OR SUPPLIER	LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146				17200
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 176	Continued From page	e 34	G	176			
	including non-healing	red on 8/1/09 with diagnoses surgical wound, abnormality ertension and chronic pain.					
	certification period ind (vacuum assisted clos change. Monday 8/3/ saline) - redress with The order did not incl	care (POC) for the initial cluded orders for "wound vac sure) changes 3w - 1st (709 irrigate with NS (normal vac dressing to vac @ 175." ude whether the negative he vac was to be continuous					
	whether the vac settir intermittent. There we Patient #1's clinical re	notes did not indicate may was for continuous or as no documentation in ecord indicating the SN overify if the pressure was termittent.					
	Patient #2						
	Patient #2 was admitt diagnoses including p dependent diabetes, i hypertension and deb	ressure ulcer, non-insulin malignant essential					
	for " SN (skilled num (decubitus) care as fo	rare (POC) included orders sing) to perform: Decub illows: Right NS (normal saline), apply					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING				
		297096	B. WING		12	/11/2009	
	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	286	ET ADDRESS, CITY, STATE, ZIP CODE 5 S JONES S VEGAS, NV 89146	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 176	hydrogel and DSD (d Patient #2's wound ca how the DSD was to the care was to be pre- Patient #2's clinical re nursing visit notes wh not have the necessal blood glucose levels. documentation indica physician of the situal documentation indica assist the patient to o getting an order for a Patient #3 Patient #3 was admitt diagnoses including of neoplasm of the lung Patient #3's clinical re documentation on a 9 note (SNVN) indicatir night of 9/5/09, went of treated and returned Patient #3's clinical re evidence the SN notif patient #3's clinical re evidence the SN notif patient #6 Patient #6 Patient #6 Patient #6 Patient #6 Patient #6 was admitt diagnoses including of	are orders did not include be secured and how often ovided. accord included seven skilled inch indicated the patient did ry equipment to check her. There was no ting the nurse notified the tion. There was no ting the nurse attempted to btain the equipment by social worker to intervene. Accord included worker to intervene. Accord included worker to include	G 176				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻	TIPLE CONSTRUCTION NG	(X3) DATE SUF COMPLET	
	297096	B. WING		12/1	1/2009
NAME OF PROVIDER OR SUPPLIER DYNAMIC HOME HEALTH CARE, LI	LC	s	TREET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	•	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
of wound care provided Recertification Assessing Multiple wound assess clinical record lacked at the wounds. The major documentation in the comparison of the wounds. The major documentation in the comparison of the wounds. The major documentation in the comparison of the wounds. The major documentation in the comparison of the wounds. Patient #13 was admitted in a Sunday, the last of SN prepared orders to times a week for two words. Patient #14 was original with diagnoses including diabetes mellitus and frextremities. Over the course of 12 readmitted to the acute on 1/22/09 for deteriors and subsequent ampuratoes; on 8/26/09 for inf 10/7/09 for respiratory the knee amputations of Patient #14's most recomparison.	cord lacked documentation d on 11/23/09 in the ment on page 10. Sement tools in Patient #6's a complete measurement of prity of nursing clinical record was illegible. Ited on 12/5/09 with steemyelitis, insulin ellitus, essential rillation and coronary Ited by skilled nursing (SN) day of the agency's week. It see the patient seven weeks. Ited by skilled nursing (SN) day of the agency's week. It see the patient seven weeks. Ited by skilled nursing (SN) day of the agency's week. It see the patient seven weeks. Ited by skilled nursing (SN) day of the agency's week. Ited by skilled nursing (SN) day of the agency is not stated to	G 17	76		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297096	B. WIN	G		12/1	1/2009
	ROVIDER OR SUPPLIER	LLC		286	ET ADDRESS, CITY, STATE, ZIP CODE 55 S JONES S VEGAS, NV 89146	,	17200
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 176	nursing, physical ther therapy. Patient #14's clinical in nursing notes, 60 day conferences and med numerous blanks, incomissing and illegible in the patient #14's clinical in order to resume physical and frequency of one ting two times a week for dated 11/6/09. The laperiod was 11/11/09, Patient #14's clinical in order to resume occu (OT) services at a free for one week, two times and once a week for dated 11/6/09. The laperiod was 11/11/09, Patient #16 Patient #16 Patient #16 was admit diagnoses including in diabetes mellitus, chromation Set) prepadmission lacked doc Patient #16's wounds The orders for wound closure) therapy in Patient was prepared to the patient wounds.	record contained multiple resummaries, case lication profiles with complete dates, signatures handwriting. record included a physician's ical therapy (PT) services at the a week for one week and three weeks. The order was last day of the certification less than one week later. record included a physician's pational therapy quency of one time a week es a week for three weeks one week. The order was last day of the certification less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later. Itted on 11/4/09 with less than one week later.	G	176			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF	
		297096	B. WIN	IG_		12/1	1/2009
	OVIDER OR SUPPLIER	LLC	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 176	nursing visit notes lad indicating the negativat continuous or intersection at the certification period physician's order for weeks. 484.30(a) DUTIES ONURSE The registered nurse family in meeting nurse the nurse instead of the certification period physician's order for weeks. 484.30(a) DUTIES ONURSE The registered nurse family in meeting nurse the nurse instead on record reviensure the nurse instead on reco	uent orders and skilled cked documentation we pressure was (to be) set mittent.		176			
	Patient #1 was admit	ted on 8/1/09 with diagnoses					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297096	B. WING	3 <u></u>		12/1 ⁻	1/2009
	OVIDER OR SUPPLIER	LLC		28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 177	of gait, essential hyper Patient #1's Plan of Comparison of Patient #1's Plan of Comparison of Patient #1's certification period independent with word patient #1's clinical results of the Caregiver was insurable to care in which was not incaregiver verbalized to performed a return decare. The goals of Patient #1 certification period incomparison of the SN notes the caregiver was insurable to care. The goals of Patient #1 certification period incomparison of the SN notes the caregiver verbalized to performed a return decare. The goals of Patient #1 certification period incomparison of the SN notes the caregiver verbalized to performed a return decare. The goals of Patient #1 certification period incomparison indication period incomparison of the SN notes the caregiver was insurable to the substitute of the s	surgical wound, abnormality ertension and chronic pain. Fare (POC) included orders (POC) included orders (POC) to instruct "home healing wound" #1's POC for the initial cluded, "Pt/pcg giver) independent with eks." #2 cord contained skilled ated 8/3, 8/6, 8/8, 8/11, 8/13, 8/21/09 which described the extracted specifically in wound indication the patient and/or tructed specifically in wound indication the patient and/or emonstration of the wound extracted, " Pt/pcg and care in 6 weeks." #2 cord contained SN notes (POC) The notes did not extracted in wound care. There was ent and/or caregiver ding and/or performed a of the wound care.	G.	177			
	T GUOTE #E WAS AUTITU	SG SH THEFTOS WILL					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF	
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	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC		2	REET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 177	dependent diabetes, hypertension and deta Patient #2's Medication patient was started or 11/23/09. A skilled nurse visit in documented evidence regarding the two new no documentation indiverbalized understand was for, when to take effects to be aware or Patient #3 Patient #3 was admitt diagnoses including preparam of the lung According to a 9/12/0 (SNVN) in Patient #3 was prescribed a new SNVN lacked document taught the patient and medication's purpose etc. There was no dopatient and/or caregivergarding the new medicated 10/26/09 in which patient was on a new was no documentation instructed the patient regarding the medical regarding the	pressure ulcer, non-insulin malignant essential bility. In Profile (MP) revealed the net Phenergan and Ativan on the dated 11/23/09 lacked the the nurse taught Patient #2 with medications. There was licating the patient ding of what the medication each medication and side of for each medication. Ited on 8/24/09 with pressure ulcer, malignant and low back pain. Ited on skilled nurse visit note is clinical record, the patient with medication (Anucort). The ented evidence the SN divor caregiver regarding the prequency, side effects, becaumented evidence the ver verbalized understanding edication. In the solution of the solution o	G	177			

CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SUF COMPLET	
	297096	B. WING			12/1	1/2009
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evidence the patient a understanding regard 484.32 THERAPY SE The qualified therapis evaluating the patient helps develop the planecessary.) This STANDARD is r	and/or caregiver verbalized ing the new medication. ERVICES t assists the physician in 's level of function, and n of care (revising it as					
Based on record revie ensure the physical th accurate plan of care (Patients #2, #22).	nerapist developed an					
Patient #2 was admitt diagnoses including p dependent diabetes, r hypertension and deb Patient #2 was admitt agency's week ends of therapist (PT) evaluat 11/16/09. The PT wrote an orde three times a week fo not specify the freque week of 11/16/09.	oressure ulcer, non-insulin malignant essential malignant essential mility. The condition of the partial matter on Sunday. The physical med the patient on Monday, For for Patient #2 to be treated or four weeks. The PT did					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR I. Continued From page evidence the patient a understanding regard 484.32 THERAPY SE The qualified therapis evaluating the patient helps develop the pla necessary.) This STANDARD is r Surveyor: 25418 Based on record revie ensure the physical tr accurate plan of care (Patients #2, #22). Findings include: Patient #2 Patient #2 Patient #2 Patient #2 was admitt diagnoses including p dependent diabetes, in hypertension and deb Patient #2 was admitt agency's week ends of therapist (PT) evaluated 11/16/09. The PT wrote an order	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 evidence the patient and/or caregiver verbalized understanding regarding the new medication. 484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the physical therapist developed an accurate plan of care for 2 of 24 patients (Patients #2, #22). Findings include: Patient #2 Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2 was admitted on a Saturday. The agency's week ends on Sunday. The physical therapist (PT) evaluated the patient on Monday, 11/16/09. The PT wrote an order for Patient #2 to be treated three times a week for four weeks. The PT did not specify the frequency was to be effective the week of 11/16/09.	DVIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 evidence the patient and/or caregiver verbalized understanding regarding the new medication. 484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the physical therapist developed an accurate plan of care for 2 of 24 patients (Patients #2, #22). Findings include: Patient #2 Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2 was admitted on a Saturday. The agency's week ends on Sunday. The physical therapist (PT) evaluated the patient on Monday, 11/16/09. The PT wrote an order for Patient #2 to be treated three times a week for four weeks. The PT did not specify the frequency was to be effective the week of 11/16/09.	DOUDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 Continued From page 41 Continued From page 41 G 177 Cross-Refered Continued From page 41 G 177 Graph Cross-Refered Cross-Refered G 186 Continued From page 41 G 177 Graph Cores Graph Cores Graph Cores Graph Cores Graph Cores Graph Cores Graph Cross-Refered G 186 G 187 G 186 G 187 G 186 G 187 G 186 G 187 G 186 G 187 G 186 G 187 G 186 G 186 G 186 G 187 G 186 G 187 G 186 G 187 G 186 G 187 G 18	DMDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSG IDENTIFYMS INFORMATION) Continued From page 41 evidence the patient and/or caregiver verbalized understanding regarding the new medication. 484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Surveyor: 254.18 Based on record review, the agency failed to ensure the physical therapist developed an accurate plan of care for 2 of 24 patients (Patients #2, #22). Findings include: Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2 was admitted on a Saturday. The agency's week ends on Sunday. The physical therapist (PT) evaluated the patient on Monday, 11/16/09.	DYIDER OR SUPPLIER HOME HEALTH CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 evidence the patient and/or caregiver verbalized understanding regarding the new medication. 484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the physical therapist developed an accurate plan of care for 2 of 24 patients (Patients #2, #22). Findings include: Patient #2 Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2 was admitted on a Saturday. The agency's week ends on Sunday. The physical therapist (PT) evaluated the patient on Monday, 11/16/09.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	
		297096	B. WIN				4/0000
	OVIDER OR SUPPLIER			28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146	12/1	1/2009
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G 186	diabetes mellitus, ost and debility. Physical therapy (PT) 5/26/09. PT wrote a frequency of three tim	itted on 5/21/09 with non insulin dependent eoarthrosis, chronic pain evaluated Patient #22 on physician's order for a nes a week for two weeks week for three weeks. The not specify the PT ective as of 5/26/09.		186			
G 236	A clinical record contacurrent findings in according professional standard patient receiving hom addition to the plan of appropriate identifying physician; drug, dietacorders; signed and danotes; copies of summer according to the context of the c	aining pertinent past and cordance with accepted is is maintained for every		236			
	Surveyor: 25418 Based on record revi						
	diagnoses including v						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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NAME OF PR	OVIDER OR SUPPLIER	297096			EET ADDRESS, CITY, STATE, ZIP CODE	12/1	1/2009
	HOME HEALTH CARE,	LLC		28	165 S JONES AS VEGAS, NV 89146		
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G 236	and morbid obesity. As of 12/11/09, there (from the referral sour Patient #6's clinical repatient #16 Patient #16 Patient #16 was admit diagnoses including rediabetes mellitus, chromatological patient #16's clinical referral sour	was no medical history ree or primary physician) in ecord. itted on 11/4/09 with non insulin dependent onic pain and open wound. was no medical history ree or primary physician) in record.	G 2	236			
	drug interactions, dup noncompliance with of This STANDARD is r Surveyor: 25418 Based on record revie ensure ongoing comp medications occurred (Patients #1, #3, #5, # Findings include:	not met as evidenced by: ew, the agency failed to prehensive assessments of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	,	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146	,	2000
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G 337	including non-healing of gait, essential hypomagait, and essential hypomagait, and essential hypomagait, essen	g surgical wound, abnormality ertension and chronic pain. y summary dated 9/1/09, actrim for eight days." The as not updated to reflect the im, the date started, dosage, tted on 8/24/09 with decubitus ulcer malignant y and low back pain. ecord included a skilled /N) dated 9/12/09 which was prescribed Anucort 25 in rectally twice a day. fon Profile was not updated to ed medication. tted on 11/29/09 with pulmonary embolism, aftercare surgery of tem, degenerative joint prining during a home visit, she had been taking a for itch (prn)) since 11/30, and since 12/2 and Albuterol for of breath) secondary to a	G	337			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	COMPLET	
		297096	B. WIN	IG		12/1	1/2009
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 337	mentioned in the present #6 Patient #6 was admit diagnoses including vinsufficiency, malignated and morbid obesity. On 12/11/09 in the material patient #6 indicated substruction. Patient #6 indicated substruction. Patient #6's MP was changes in the three the previous paragramal Patient #7 Patient #7 was admit diagnoses including on the hypertension, non-insumellitus, bronchitis an obstruction. Patient #7's Plan of Control of the following of the following for the follow	the three medications vious paragraph. Ited on 9/30/08 with venous peripheral ant essential hypertension orning during a home visit, she had been taking: rams every day since grams two tabs twice a day as a day, Medication Profile (/); e only (MP read three times a line of the medications mentioned in oh. Ited on 11/20/09 with debility, essential sulin dependent diabetes and chronic airway Care (POC) for the 11/20/09 - 1/18/10 included	G	337			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	ROVIDER OR SUPPLIER HOME HEALTH CARE,	LLC	·	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
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G 337	day Singulair 10 mg or hours Fioricet 200 mg on a day prn (as needed On 12/4/09 in the mo with the physical thermedications with the supplements and overpharmaceuticals: Januvia 25 mg one day Alprazolam 0.5 mg times a day (dated 9/ Hyzaar 100/12.5 m a day Singulair 10 mg or Klor-Con 10 millied mouth once a day Toprol 50 mg one Patanol 0.1% eye twice a day Lumigan eye drops daily in the evening I-Caps two capsule or day Stool softener one day Stool softener one day Patient #7's clinical renurse visit note dated documented, " Azith per dose pack times to	te tablet by mouth once a te tablet by mouth every 12 te tablet by mouth four times for) pain rning during a home visit apist, Patient #7 presented following prescription labels, r-the-counter e tablet by mouth two times a gone tablet by mouth two 6/09) ng one tablet by mouth once the by mouth once a day quivalents one table by tablet by mouth once a day drops one drop each eye as once a day with meals the capsule by mouth once a	G	337			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		297096	B. WIN	G		12/1 ⁻	1/2009
	OVIDER OR SUPPLIER	LLC	•	28	EET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES AS VEGAS, NV 89146		
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G 337	above mentioned men Azithromycin). Patient #8 Patient #8 was admitt diagnoses including in mellitus, diabetic ulce chronic airway obstruton on 12/4/09 in the more patient #8's medication bottle with a label whin milligrams (mg) one to the wind of the with a label whin milligrams (mg) one to the with a label whin milligrams (mg) one to the with a label whin milligrams (mg) one to the with a label whin milligrams (mg) one to the with a label whin milligrams (mg) one to the with a label whin milligrams (mg) one to the with a label whin milligrams by mouth end with a label whin milligrams by mouth end with a label whin milligrams by mouth end with a label with a label whin milligrams by mouth end with a label with a label whin milligrams by mouth end with a label with a label whin milligrams by mouth end with a label with a label whin milligrams by mouth end with a label whin milligrams by milligrams by mouth end with a label whin milligram w	ted on 10/28/08 with insulin dependent diabetes of the lower leg and oction. Trining during a home visit, ons included a prescription ich read, "Diovan Hot 320/25 ablet by mouth once a day." The of Risperdal with a label of the mg one tablet every day dication had a dispense Trent Medication Profile (MP) one mg one tablet every did one mg one tablet every Ted on 2/25/09 with one mg one tablet every Ted on 2/25/09 with one mg one tablet every Ted on 2/25/09 with one mg one tablet every	G	337			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		297096	B. WIN	B. WING		12/11/2009	
NAME OF PROVIDER OR SUPPLIER DYNAMIC HOME HEALTH CARE, LLC				2	REET ADDRESS, CITY, STATE, ZIP CODE 865 S JONES .AS VEGAS, NV 89146		
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G 337	evidence of being upon of Docusate. Patient #12 Patient #12 was admidiagnoses including eabnormality of gait and On 12/8/09 in the more patient #12 had a both prescription label which Hydrochloride 75 millimouth twice a day." Patient #12 had a both 220 mg and indicated mouth twice a day as patient indicated the and was taking the All Patient #12 indicated Calcium with Vitamin 11/30), Megestrol (as of discontinuation unknown patient #12's medicated documented evidence the patient #13 Patient #13 Patient #13 Patient #13 was admidiagnoses including of dependent diabetes in the patient #13	2/21/09 lacked documented dated to reflect the addition dated on 11/15/09 with essential hypertension, and acute pain. In the of acute pain	G	337			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297096	B. WING			12/11/2009		
NAME OF PROVIDER OR SUPPLIER DYNAMIC HOME HEALTH CARE, LLC			•	2865	T ADDRESS, CITY, STATE, ZIP CODE 5 S JONES 5 VEGAS, NV 89146			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	SHOULD BE COMPLETION		
G 337	A 7/23/09 postoperat form revealed Patien new medications (Lo 7/13/09 medication p reflect these two new	ive discharge instruction t #13 was prescribed two rtab and Keflex). The rofile was not updated to medications.		337				
	The comprehensive a updated and revised of the OASIS) the last beginning with the states a beneficiary electer change in condition recommendation.	ASSESSMENT assessment must be (including the administration of 5 days of every 60 days eart of care date, unless there ed transfer; or significant esulting in a new case mix large and return to the same						
	Surveyor: 25418 Based on record reviensure a recertification completed during the							
	Patient #9 was admit diagnoses including p essential hypertensic pain.	ted on 2/25/09 with pressure ulcer of the buttock, on, obesity and low back essment dated 10/17/09						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET	(X3) DATE SURVEY COMPLETED	
		297096	B. WING		12/11/2009		
NAME OF PROVIDER OR SUPPLIER DYNAMIC HOME HEALTH CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2865 S JONES LAS VEGAS, NV 89146				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
G 339		erformed the recertification prior to the first day of the	G 339				